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[COMMITTEE PRINT]

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION DRUG BENEFIT.

(a) IN GENERAL.—Title XVIII is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

"PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

"SEC. 1860A. BENEFITS; ELIGIBILITY; ENROLLMENT; AND COVERAGE PERIOD.

"(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject to the succeeding provisions of this part, each individual who is entitled to benefits under part A or is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860B(a)) as follows:

"(1) MEDICARE+CHOICE PLAN.—If the individual is eligible to enroll in a Medicare+Choice plan that provides qualified prescription drug coverage under section 1851(j), the individual may enroll in the plan and obtain coverage through such plan.

"(2) PRESCRIPTION DRUG PLAN.—If the individual is not enrolled in a Medicare+Choice plan that provides qualified prescription drug coverage, the individual may enroll under this part in a prescription drug plan (as defined in section 1860J(a)(5)).

Such individuals shall have a choice of such plans under section 1860E(d).

"(b) GENERAL ELECTION PROCEDURES.—

"(1) IN GENERAL.—An individual eligible to make an election under subsection (a) may elect to enroll in a prescription drug plan under this part, or elect the option of qualified prescription drug coverage under a Medicare+Choice plan under part C, and to change such

election only in such manner and form as may be prescribed by regulations of the Administrator of the Medicare Benefits Administration (appointed under section 1808(b)) (in this part referred to as the 'Medicare Benefits Administrator') and only during an election period prescribed in or under this subsection.

"(2) ELECTION PERIODS.—

"(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare+Choice program under section 1851(e), including—

"(i) annual coordinated election periods; and

"(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug plan under this part at the time of the election of coverage under the original fee-for-service plan.

"(B) INITIAL ELECTION PERIODS.—

"(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2004, there shall be an initial election period of 6 months beginning on that date.

"(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

"(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

"(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in subsection (c)(2)(C);

"(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B;

"(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Administrator may provide; and

"(iv) in cases of individuals (as determined by the Administrator) who become eligible for prescription drug assistance under title XIX under section 1935(d).

"(c) GUARANTEED ISSUE; COMMUNITY RATING; AND NONDISCRIMINATION.—

"(1) GUARANTEED ISSUE.—

"(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or Medicare+Choice plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

"(B) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to PDP sponsors under this subsection.

"(2) COMMUNITY-RATED PREMIUM.—

"(A) IN GENERAL.—In the case of an individual who maintains (as determined under subparagraph (C))

continuous prescription drug coverage since the date the individual first qualifies to elect prescription drug coverage under this part, a PDP sponsor or Medicare+Choice organization offering a prescription drug plan or Medicare+Choice plan that provides qualified prescription drug coverage and in which the individual is enrolled may not deny, limit, or condition the coverage or provision of covered prescription drug benefits or increase the premium under the plan based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act or any other factor.

"(B) LATE ENROLLMENT PENALTY.—In the case of an individual who does not maintain such continuous prescription drug coverage (as described in subparagraph (C)), a PDP sponsor or Medicare+Choice organization may (notwithstanding any provision in this title) adjust the premium otherwise applicable or impose a pre-existing condition exclusion with respect to qualified prescription drug coverage in a manner that reflects additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraphs (A) through (C) of section 2103(c)(4).

"(C) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

"(i) COVERAGE UNDER PRESCRIPTION DRUG PLAN OR MEDICARE+CHOICE PLAN.—Qualified prescription drug coverage under a prescription drug plan or under a Medicare+Choice plan.

"(ii) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

"(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860H(f)(1), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

"(iv) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)), but only if the policy was in effect on January 1, 2005, and if (subject to subparagraph

(E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

"(v) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

"(vi) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

"(D) CERTIFICATION.—For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in subparagraph (C).

"(E) DISCLOSURE.—

"(i) IN GENERAL.—Each entity that offers coverage of the type described in clause (iii), (iv), (v), or (vi) of subparagraph (C) shall provide for disclosure, consistent with standards established by the Administrator, of whether such coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

"(ii) WAIVER OF LIMITATIONS.—An individual may apply to the Administrator to waive the requirement that coverage of such type provide benefits at least equivalent to the benefits under a qualified prescription drug plan, if the individual establishes that the individual was not adequately

informed that such coverage did not provide such level of benefits.

"(F) CONSTRUCTION.—Nothing in this section shall be construed as preventing the disenrollment of an individual from a prescription drug plan or a Medicare+Choice plan based on the termination of an election described in section 1851(g)(3), including for non-payment of premiums or for other reasons specified in subsection (d)(3), which takes into account a grace period described in section 1851(g)(3)(B)(i).

"(3) NONDISCRIMINATION.—A PDP sponsor offering a prescription drug plan shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

"(d) EFFECTIVE DATE OF ELECTIONS.—

"(1) IN GENERAL.—Except as provided in this section, the Administrator shall provide that elections under subsection (b) take effect at the same time as the Administrator provides that similar elections under section 1851(e) take effect under section 1851(f).

"(2) NO ELECTION EFFECTIVE BEFORE 2005.—In no case shall any election take effect before January 1, 2005.

"(3) TERMINATION.—The Administrator shall provide for the termination of an election in the case of—

"(A) termination of coverage under both part A and part B; and

"(B) termination of elections described in section 1851(g)(3) (including failure to pay required premiums).

"SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

"(a) REQUIREMENTS.—

"(1) IN GENERAL.—For purposes of this part and part C, the term 'qualified prescription drug coverage' means either of the following:

"(A) STANDARD COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard coverage (as defined in

subsection (b)) and access to negotiated prices under subsection (d).

"(B) ACTUARIALLY EQUIVALENT COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered outpatient drugs which meets the alternative coverage requirements of subsection (c) and access to negotiated prices under subsection (d), but only if it is approved by the Administrator, as provided under subsection (c).

"(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

"(A) IN GENERAL.—Subject to subparagraph (B), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1), but any such additional coverage shall be limited to coverage of covered outpatient drugs.

"(B) DISAPPROVAL AUTHORITY.—The Administrator shall review the offering of qualified prescription drug coverage under this part or part C. If the Administrator finds that, in the case of a qualified prescription drug coverage under a prescription drug plan or a Medicare+Choice plan, that the organization or sponsor offering the coverage is engaged in activities intended to discourage enrollment of classes of eligible medicare beneficiaries obtaining coverage through the plan on the basis of their higher likelihood of utilizing prescription drug coverage, the Administrator may terminate the contract with the sponsor or organization under this part or part C.

"(3) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C.

"(b) STANDARD COVERAGE.—For purposes of this part, the 'standard coverage' is coverage of covered outpatient drugs

(as defined in subsection (f)) that meets the following requirements:

"(1) DEDUCTIBLE.—The coverage has an annual deductible—

"(A) for 2005, that is equal to $250; or

"(B) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

"(2) LIMITS ON COST-SHARING.—

"(A) IN GENERAL.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) as follows:

"(i) FIRST COPAYMENT RANGE.—For costs above the annual deductible specified in paragraph (1) and up to amount specified in subparagraph (C), the cost-sharing—

"(I) is equal to 20 percent; or

"(II) is actuarially equivalent (using processes established under subsection (e)) to an average expected payment of 20 percent of such costs.

"(ii) SECONDARY COPAYMENT RANGE.—For costs above the amount specified in subparagraph (C) and up to the initial coverage limit, the cost-sharing—

"(I) is equal to 50 percent; or

"(II) is actuarially consistent (using processes established under subsection (e)) with an average expected payment of 50 percent of such costs.

"(B) USE OF TIERED COPAYMENTS.—Nothing in this part shall be construed as preventing a PDP spon-

sor from applying tiered copayments, so long as such tiered copayments are consistent with subparagraph (A).

"(C) INITIAL COPAYMENT THRESHOLD.—The amount specified in this subparagraph—

"(i) for 2005, is equal to $1,000; or

"(ii) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under clause (ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

"(3) INITIAL COVERAGE LIMIT.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (above the annual deductible)—

"(A) for 2005, that is equal to $2,000; or

"(B) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $25 shall be rounded to the nearest multiple of $25.

"(4) CATASTROPHIC PROTECTION.—

"(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits with no cost-sharing after the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket threshold specified in subparagraph (B).

"(B) ANNUAL OUT-OF-POCKET THRESHOLD.—For purposes of this part, the 'annual out-of-pocket threshold' specified in this subparagraph—

"(i) for 2005, is equal to $4,500; or

"(ii) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under clause (ii) that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

"(C) APPLICATION.—In applying subparagraph (A)—

"(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); and

"(ii) such costs shall be treated as incurred only if they are paid by the individual, under section 1860G, or under title XIX and the individual is not reimbursed (through insurance or otherwise) by another person for such costs.

"(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs in the United States for medicare beneficiaries, as determined by the Administrator for the 12-month period ending in July of the previous year.

"(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or Medicare+Choice plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b) so long as the following requirements are met and the plan applies for, and receives, the approval of the Administrator for such benefit design:

"(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

"(A) ASSURING EQUIVALENT VALUE OF TOTAL COVERAGE.—The actuarial value of the total coverage (as determined under subsection (e)) is at least equal to the actuarial value (as so determined) of standard coverage.

"(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (e)) exceeds the actuarial value of the subsidy payments under section 1860H with respect to such coverage.

"(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (e)), to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3), of an amount equal to at least the sum of the following products:

"(i) FIRST COPAYMENT RANGE.—The product of—

"(I) the amount by which the initial copayment threshold described in subsection (b)(2)(C) exceeds the deductible described in subsection (b)(1); and

"(II) 100 percent minus the cost-sharing percentage specified in subsection (b)(2)(A)(i)(I).

"(ii) SECONDARY COPAYMENT RANGE.—The product of—

"(I) the amount by which the initial coverage limit described in subsection (b)(3) exceeds the initial copayment threshold described in subsection (b)(2)(C); and

"(II) 100 percent minus the cost-sharing percentage specified in subsection (b)(2)(A)(ii)(I).

"(2) CATASTROPHIC PROTECTION.—The coverage provides for beneficiaries the catastrophic protection described in subsection (b)(4).

"(d) ACCESS TO NEGOTIATED PRICES.—

"(1) IN GENERAL.—Under qualified prescription drug coverage offered by a PDP sponsor or a Medicare+Choice organization, the sponsor or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of cost-sharing or an initial coverage limit (described in subsection (b)(3)). Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated by a prescription drug plan under this part, the requirements of section 1927 shall not apply to such drugs.

"(2) DISCLOSURE.—The PDP sponsor or Medicare+Choice organization shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts or rebates made available to the sponsor or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

"(e) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

"(1) PROCESSES.—For purposes of this section, the Administrator shall establish processes and methods—

"(A) for determining the actuarial valuation of prescription drug coverage, including—

"(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 1860H;

"(ii) the use of generally accepted actuarial principles and methodologies; and

"(iii) applying the same methodology for determinations of alternative coverage under subsection (c) as is used with respect to determinations of standard coverage under subsection (b); and

"(B) for determining annual percentage increases described in subsection (b)(5).

"(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), PDP sponsors and Medicare+Choice organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

"(f) COVERED OUTPATIENT DRUGS DEFINED.—

"(1) IN GENERAL.—Except as provided in this subsection, for purposes of this part, the term 'covered outpatient drug' means—

"(A) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

"(B) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section,

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(2) EXCLUSIONS.—

"(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E)

thereof (relating to smoking cessation agents), or under section 1927(d)(3).

"(B) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

"(3) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860C(f)(2).

"(4) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered outpatient drug—

"(A) for which payment would not be made if section 1862(a) applied to part D; or

"(B) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860C(f).

"SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

"(a) GUARANTEED ISSUE, COMMUNITY-RELATED PREMIUMS, ACCESS TO NEGOTIATED PRICES, AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, access to negotiated prices, and nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2), 1860B(d), and 1860F(b), respectively.

"(b) DISSEMINATION OF INFORMATION.—

"(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at

least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

"(A) Access to covered outpatient drugs, including access through pharmacy networks.

"(B) How any formulary used by the sponsor functions.

"(C) Co-payments and deductible requirements, including the identification of the tiered or other co-payment level applicable to each drug (or class of drugs).

"(D) Grievance and appeals procedures.

"(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll under a prescription drug plan, the PDP sponsor shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such individual.

"(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information to enrollees upon request. The sponsor shall make available on a timely basis, through an Internet website and in writing upon request, information on specific changes in its formulary.

"(4) CLAIMS INFORMATION.—Each PDP sponsor offering a prescription drug plan must furnish to enrolled individuals in a form easily understandable to such individuals an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and annual out-of-pocket threshold for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

"(c) ACCESS TO COVERED BENEFITS.—

"(1) ASSURING PHARMACY ACCESS.—

"(A) IN GENERAL.—The PDP sponsor of the prescription drug plan shall secure the participation in its

network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Administrator and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(e) that ensure such convenient access.

"(B) USE OF POINT-OF-SERVICE SYSTEM.—A PDP sponsor shall establish an optional point-of-service method of operation under which—

"(i) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

"(ii) the plan may charge beneficiaries through adjustments in premiums and copayments any additional costs associated with the point-of-service option.

The additional copayments so charged shall not count toward the application of section 1860B(b).

"(2) USE OF STANDARDIZED TECHNOLOGY.—

"(A) IN GENERAL.—The PDP sponsor of a prescription drug plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860B(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug plan.

"(B) STANDARDS.—

"(i) DEVELOPMENT.—The Administrator shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in subparagraph (A). Such standards shall be compatible with standards established under part C of title XI.

"(ii) APPLICATION OF ADVISORY TASK FORCE.—The advisory task force established under subsection (d)(3)(B)(ii) shall provide recommenda-

tions to the Administrator under such subsection regarding the standards developed under clause (i).

"(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a PDP sponsor of a prescription drug plan uses a formulary, the following requirements must be met:

"(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The sponsor must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least one physician and at least one pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a pharmacist (or both).

"(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

"(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (although not necessarily for all drugs within such categories and classes).

"(D) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

"(E) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and physicians.

"(F) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating

to grievances and appeals of coverage, see subsections (e) and (f).

"(d) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

"(1) IN GENERAL.—The PDP sponsor shall have in place with respect to covered outpatient drugs—

"(A) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

"(B) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in paragraph (2) and for years beginning with 2006, an electronic prescription program described in paragraph (3); and

"(C) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing a PDP sponsor from applying cost management tools (including differential payments) under all methods of operation.

"(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

"(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered outpatient drugs under the prescription drug plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

"(B) ELEMENTS.—Such program may include—

"(i) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

"(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

"(iii) detection of patterns of overuse and underuse of prescription drugs.

"(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed pharmacists and physicians.

"(D) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug program shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

"(3) ELECTRONIC PRESCRIPTION PROGRAM.—

"(A) IN GENERAL.—An electronic prescription drug program described in this paragraph is a program that includes at least the following components, consistent with national standards established under subparagraph (B):

"(i) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—Prescriptions are only received electronically, except in emergency cases and other exceptional circumstances recognized by the Administrator.

"(ii) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL.—The program provides, upon transmittal of a prescription by a prescribing health care professional, for transmittal by the pharmacist to the professional of information that includes—

"(I) information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medical history or condition of the patient

that may be relevant to the appropriate prescription for that patient;

"(II) cost-effective alternatives (if any) for the use of the drug prescribed; and

"(III) information on the drugs included in the applicable formulary.

To the extent feasible, such program shall permit the prescribing health care professional to provide (and be provided) related information on an interactive, real-time basis.

"(B) STANDARDS.—

"(i) DEVELOPMENT.—The Administrator shall provide for the development of national standards relating to the electronic prescription drug program described in subparagraph (A). Such standards shall be compatible with standards established under part C of title XI.

"(ii) ADVISORY TASK FORCE.—In developing such standards and the standards described in subsection (c)(2)(B)(i) the Administrator shall establish a task force that includes representatives of physicians, hospitals, pharmacists, and technology experts and representatives of the Departments of Veterans Affairs and Defense and other appropriate Federal agencies to provide recommendations to the Administrator on such standards, including recommendations relating to the following:

"(I) The range of available computerized prescribing software and hardware and their costs to develop and implement.

"(II) The extent to which such systems reduce medication errors and can be readily implemented by physicians and hospitals.

"(III) Efforts to develop a common software platform for computerized prescribing.

"(IV) The cost of implementing such systems in the range of hospital and physician of-

fice settings, including hardware, software, and training costs.

"(V) Implementation issues as they relate to part C of title XI, and current Federal and State prescribing laws and regulations and their impact on implementation of computerized prescribing.

"(iii) DEADLINES.—

"(I) The Administrator shall constitute the task force under clause (ii) by not later than April 1, 2003.

"(II) Such task force shall submit recommendations to Administrator by not later than January 1, 2004.

"(III) The Administrator shall develop and promulgate the national standards referred to in clause (ii) by not later than July 1, 2004.

"(C) REFERENCE TO AVAILABILITY OF GRANT FUNDS.—Grant funds are authorized under section 3990 of the Public Health Service Act to provide assistance to health care providers in implementing electronic prescription drug programs.

"(4) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug plans under this part with respect to the following requirements, in the same manner as they apply to Medicare+Choice plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

"(A) Paragraph (1) (including quality assurance), including medication therapy management program under paragraph (2).

"(B) Subsection (c)(1) (relating to access to covered benefits).

"(C) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

"(5) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each PDP sponsor shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

"(e) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

"(1) IN GENERAL.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1852(f).

"(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

"(3) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug plan offered by a PDP sponsor that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

"(f) APPEALS.—

"(1) IN GENERAL.—Subject to paragraph (2), a PDP sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

"(2) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal to obtain coverage for a covered outpatient drug that is not on a formulary of the sponsor if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

"(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—A PDP sponsor shall meet the requirements of section 1852(h) with respect to enrollees under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to enrollees under part C.

"SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG PLAN (PDP) SPONSORS; CONTRACTS; ESTABLISHMENT OF STANDARDS.

"(a) GENERAL REQUIREMENTS.—Each PDP sponsor of a prescription drug plan shall meet the following requirements:

"(1) LICENSURE.—Subject to subsection (c), the sponsor is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a prescription drug plan.

"(2) ASSUMPTION OF FINANCIAL RISK.—

"(A) IN GENERAL.—Subject to subparagraph (B) and section 1860E(d)(2), the entity assumes full financial risk on a prospective basis for qualified prescription drug coverage that it offers under a prescription drug plan and that is not covered under section 1860H.

"(B) REINSURANCE PERMITTED.—The entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

"(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a sponsor that is not described in paragraph (1), the sponsor shall meet solvency standards established by the Administrator under subsection (d).

"(b) CONTRACT REQUIREMENTS.—

"(1) IN GENERAL.—The Administrator shall not permit the election under section 1860A of a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860G or 1860H, unless the Administrator has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

"(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—The Administrator shall have the same authority to negotiate the terms and conditions of prescription drug plans under this part as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code. In negotiating the terms and conditions regarding premiums for which information is submitted under section 1860F(a)(2), the Administrator shall take into account the subsidy payments under section 1860H and the adjusted community rate (as defined in section 1854(f)(3)) for the benefits covered.

"(3) INCORPORATION OF CERTAIN MEDICARE+CHOICE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(5), to

contracts under this section in the same manner as they apply to contracts under section 1857(a):

"(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b).

"(B) CONTRACT PERIOD AND EFFECTIVENESS.—Paragraphs (1) through (3) and (5) of section 1857(c).

"(C) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

"(D) ADDITIONAL CONTRACT TERMS.—Section 1857(e); except that in applying section 1857(e)(2) under this part—

"(i) such section shall be applied separately to costs relating to this part (from costs under part C);

"(ii) in no case shall the amount of the fee established under this subparagraph for a plan exceed 20 percent of the maximum amount of the fee that may be established under subparagraph (B) of such section; and

"(iii) no fees shall be applied under this subparagraph with respect to Medicare+Choice plans.

"(E) INTERMEDIATE SANCTIONS.—Section 1857(g).

"(F) PROCEDURES FOR TERMINATION.—Section 1857(h).

"(4) RULES OF APPLICATION FOR INTERMEDIATE SANCTIONS.—In applying paragraph (3)(E)—

"(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

"(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

"(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

"(1) IN GENERAL.—In the case of an entity that seeks to offer a prescription drug plan in a State, the Administrator shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Administrator de-

termines, based on the application and other evidence presented to the Administrator, that any of the grounds for approval of the application described in paragraph (2) has been met.

"(2) GROUNDS FOR APPROVAL.—The grounds for approval under this paragraph are the grounds for approval described in subparagraph (B), (C), and (D) of section 1855(a)(2), and also include the application by a State of any grounds other than those required under Federal law.

"(3) APPLICATION OF WAIVER PROCEDURES.—With respect to an application for a waiver (or a waiver granted) under this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply.

"(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) does not deem the entity to meet other requirements imposed under this part for a PDP sponsor.

"(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying provisions of section 1855(a)(2) under this subsection to prescription drug plans and PDP sponsors—

"(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1); and

"(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d).

"(d) SOLVENCY STANDARDS FOR NON-LICENSED SPONSORS.—

"(1) ESTABLISHMENT.—The Administrator shall establish, by not later than October 1, 2003, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

"(2) COMPLIANCE WITH STANDARDS.—Each PDP sponsor that is not licensed by a State under subsection

(a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Administrator shall establish certification procedures for such PDP sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

"(e) OTHER STANDARDS.—The Administrator shall establish by regulation other standards (not described in subsection (d)) for PDP sponsors and plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by October 1, 2003.

"(f) RELATION TO STATE LAWS.—

"(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency, except as provided in subsection (d)) with respect to prescription drug plans which are offered by PDP sponsors under this part.

"(2) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums paid to PDP sponsors for prescription drug plans under this part, or with respect to any payments made to such a sponsor by the Administrator under this part.

"SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT QUALIFIED PRESCRIPTION DRUG COVERAGE.

"(a) IN GENERAL.—The Administrator shall establish a process for the selection of the prescription drug plan or Medicare+Choice plan which offer qualified prescription drug coverage through which eligible individuals elect qualified prescription drug coverage under this part.

"(b) ELEMENTS.—Such process shall include the following:

"(1) Annual, coordinated election periods, in which such individuals can change the qualifying plans through

which they obtain coverage, in accordance with section 1860A(b)(2).

"(2) Active dissemination of information to promote an informed selection among qualifying plans based upon price, quality, and other features, in the manner described in (and in coordination with) section 1851(d), including the provision of annual comparative information, maintenance of a toll-free hotline, and the use of non-Federal entities.

"(3) Coordination of elections through filing with a Medicare+Choice organization or a PDP sponsor, in the manner described in (and in coordination with) section 1851(c)(2).

"(c) MEDICARE+CHOICE ENROLLEE IN PLAN OFFERING PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN BENEFITS THROUGH THE PLAN.—An individual who is enrolled under a Medicare+Choice plan that offers qualified prescription drug coverage may only elect to receive qualified prescription drug coverage under this part through such plan.

"(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

"(1) CHOICE OF AT LEAST TWO PLANS IN EACH AREA.—

"(A) IN GENERAL.—The Administrator shall assure that each individual who is entitled to benefits under part A or enrolled under part B and who is residing in an area in the United States has available, consistent with subparagraph (B), a choice of enrollment in at least two qualifying plans (as defined in paragraph (5)) in the area in which the individual resides, at least one of which is a prescription drug plan.

"(B) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in subparagraph (A) is not satisfied with respect to an area if only one PDP sponsor or Medicare+Choice organization offers all the qualifying plans in the area.

"(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) and consistent with

paragraph (3), the Administrator may provide financial incentives (including partial underwriting of risk) for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

"(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Administrator—

"(A) shall not provide for the full underwriting of financial risk for any PDP sponsor;

"(B) shall not provide for any underwriting of financial risk for a public PDP sponsor with respect to the offering of a nationwide prescription drug plan; and

"(C) shall seek to maximize the assumption of financial risk by PDP sponsors or Medicare+Choice organizations.

"(4) REPORTS.—The Administrator shall, in each annual report to Congress under section 1808(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

"(5) QUALIFYING PLAN DEFINED.—For purposes of this subsection, the term 'qualifying plan' means a prescription drug plan or a Medicare+Choice plan that includes qualified prescription drug coverage.

"SEC. 1860F. SUBMISSION OF BIDS.

"(a) SUBMISSION OF BIDS AND RELATED INFORMATION.—

"(1) IN GENERAL.—Each PDP sponsor shall submit to the Administrator information of the type described in paragraph (2) in the same manner as information is submitted by a Medicare+Choice organization under section 1854(a)(1).

"(2) TYPE OF INFORMATION.—The information described in this paragraph is the following:

"(A) Information on the qualified prescription drug coverage to be provided.

"(B) Information on the actuarial value of the coverage.

"(C) Information on the bid for the coverage, including an actuarial certification of—

"(i) the actuarial basis for such bid;

"(ii) the portion of such bid attributable to benefits in excess of standard coverage; and

"(iii) the reduction in such bid resulting from the subsidy payments provided under section 1860H.

"(D) Such other information as the Administrator may require to carry out this part.

"(3) REVIEW.—The Administrator shall review the information filed under paragraph (2) for the purpose of conducting negotiations under section 1860D(b)(2).

"(b) UNIFORM BID.—

"(1) IN GENERAL.—The bid for a prescription drug plan under this section may not vary among individuals enrolled in the plan in the same service area.

"(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing the imposition of a late enrollment penalty under section 1860A(c)(2)(B).

"(c) COLLECTION.—

"(1) USE OF ELECTRONIC FUNDS TRANSFER MECHANISM OR, AT BENEFICIARY'S OPTION, WITHHOLDING FROM SOCIAL SECURITY PAYMENT.—In accordance with regulations, a PDP sponsor may encourage that enrollees under a plan make payment of the premium established by the plan under this part through an electronic funds transfer mechanism, such as automatic charges of an account at a financial institution or a credit or debit card account, or, at the option of an enrollee, through withholding from benefit payments in the manner provided under section 1840

with respect to monthly premiums under section 1839. All such amounts shall be credited to the Medicare Prescription Drug Trust Fund.

"(2) OFFSETTING.—Reductions in premiums for coverage under parts A and B as a result of a selection of a Medicare+Choice plan may be used to reduce the premium otherwise imposed under paragraph (1).

"(3) PAYMENT OF PLANS.—PDP plans shall receive payment based on bid amounts in the same manner as Medicare+Choice organizations receive payment based on bid amounts under section 1853(a)(1)(A)(ii) except that such payment shall be made from the Medicare Prescription Drug Trust Fund.

"(d) ACCEPTANCE OF BENCHMARK AMOUNT AS FULL PREMIUM FOR SUBSIDIZED LOW-INCOME INDIVIDUALS IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—

"(1) IN GENERAL.—If there is no standard prescription drug coverage (as defined in paragraph (2)) offered in an area, in the case of an individual who is eligible for a premium subsidy under section 1860G and resides in the area, the PDP sponsor of any prescription drug plan offered in the area (and any Medicare+Choice organization that offers qualified prescription drug coverage in the area) shall accept the benchmark bid amount (under section 1860G(b)(2)) as payment in full for the premium charge for qualified prescription drug coverage.

"(2) STANDARD PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this subsection, the term 'standard prescription drug coverage' means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

"SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

"(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF FEDERAL POVERTY LEVEL.—

"(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual (as defined in paragraph (4)) who is determined to have income that does not exceed 150 percent of the Federal poverty level, the individual is entitled under this section—

"(A) to an income-related premium subsidy equal to 100 percent of the amount described in subsection (b)(1); and

"(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860B(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that do not exceed $2 for a multiple source or generic drug (as described in section 1927(k)(7)(A)) and $5 for a non-preferred drug.

"(2) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME ABOVE 150, BUT BELOW 175 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual who is determined to have income that exceeds 150 percent, but does not exceed 175 percent, of the Federal poverty level, the individual is entitled under this section to—

"(A) an income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (b)(1) for individuals with incomes at 150 percent of such level to 0 percent of such amount for individuals with incomes at 175 percent of such level; and

"(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860B(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that do not exceed $2 for a multiple source or generic drug (as described in section 1927(k)(7)(A)) and $5 for a non-preferred drug.

"(3) CONSTRUCTION.—Nothing in this section shall be construed as preventing a PDP sponsor from reducing to 0 the cost-sharing otherwise applicable to generic drugs.

"(4) DETERMINATION OF ELIGIBILITY.—

"(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term 'subsidy eligible individual' means an individual who—

"(i) is eligible to elect, and has elected, to obtain qualified prescription drug coverage under this part;

"(ii) has income below 175 percent of the Federal poverty line; and

"(iii) meets the resources requirement described in section 1905(p)(1)(C).

"(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator.

"(C) INCOME DETERMINATIONS.—For purposes of applying this section—

"(i) income shall be determined in the manner described in section 1905(p)(1)(B); and

"(ii) the term 'Federal poverty line' means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(D) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of

the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

"(E) TREATMENT OF CONFORMING MEDIGAP POLICIES.—For purposes of this section, the term 'qualified prescription drug coverage' includes a medicare supplemental policy described in section 1860H(b)(4).

"(5) INDEXING DOLLAR AMOUNTS.—

"(A) FOR 2006.—The dollar amounts applied under paragraphs (1)(B) and (2)(B) for 2006 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2006.

"(B) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraphs (1)(B) and (2)(B) for a year after 2006 shall be the amounts (under this paragraph) applied under paragraph (1)(B) or (2)(B) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

"(b) PREMIUM SUBSIDY AMOUNT.—

"(1) IN GENERAL.—The premium subsidy amount described in this subsection for an individual residing in an area is the benchmark bid amount (as defined in paragraph (2)) for qualified prescription drug coverage offered by the prescription drug plan or the Medicare+Choice plan in which the individual is enrolled.

"(2) BENCHMARK BID AMOUNT DEFINED.—For purposes of this subsection, the term 'benchmark bid amount' means, with respect to qualified prescription drug coverage offered under—

"(A) a prescription drug plan that—

"(i) provides standard coverage (or alternative prescription drug coverage the actuarial value is

equivalent to that of standard coverage), the bid amount for enrollment under the plan under this part (determined without regard to any subsidy under this section or any late enrollment penalty under section 1860A(c)(2)(B)); or

"(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the bid amount described in clause (i) multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

"(B) a Medicare+Choice plan, the portion of the bid amount that is attributable to statutory drug benefits (described in section 1853(a)(1)(A)(ii)(II)).

"(c) RULES IN APPLYING COST-SHARING SUBSIDIES.—

"(1) IN GENERAL.—In applying subsections (a)(1)(B) and (a)(2)(B), nothing in this part shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

"(2) LIMITATION ON CHARGES.—In the case of an individual receiving cost-sharing subsidies under subsection (a)(1)(B) or (a)(2)(B), the PDP sponsor may not charge more than $5 per prescription.

"(3) APPLICATION OF INDEXING RULES.—The provisions of subsection (a)(4) shall apply to the dollar amount specified in paragraph (2) in the same manner as they apply to the dollar amounts specified in subsections (a)(1)(B) and (a)(2)(B).

"(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in prescription drug plan or is enrolled in a Medicare+Choice plan under which qualified prescription drug coverage is provided—

"(1) the Administrator provides for a notification of the PDP sponsor or Medicare+Choice organization in-

volved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

"(2) the sponsor or organization involved reduces the premiums or cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information on the amount of such reduction; and

"(3) the Administrator periodically and on a timely basis reimburses the sponsor or organization for the amount of such reductions.

The reimbursement under paragraph (3) with respect to cost-sharing subsidies may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

"(e) RELATION TO MEDICAID PROGRAM.—

"(1) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

"(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX.

"(3) COORDINATION.—The Administrator shall develop and implement a plan for the coordination of prescription drug benefits under this part with the benefits provided under the medicaid program under title XIX, with particular attention to insuring coordination of payments and prevention of fraud and abuse. In developing and implementing such plan, the Administrator shall involve the Secretary, the States, the data processing industry, pharmacists, and pharmaceutical manufacturers, and other experts.

"SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

"(a) SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all

medicare beneficiaries, to reduce adverse selection among prescription drug plans and Medicare+Choice plans that provide qualified prescription drug coverage, and to promote the participation of PDP sponsors under this part, the Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the following subsidies:

"(1) DIRECT SUBSIDY.—In the case of an individual enrolled in a prescription drug plan, Medicare+Choice plan, or qualified retiree prescription drug plan, a direct subsidy equal to a percentage (specified by the Administrator consistent with subsection (d)(2)) of an amount equal to the actuarial value of the standard drug coverage provided under the respective plan.

"(2) SUBSIDY THROUGH REINSURANCE.—The reinsurance payment amount (as defined in subsection (c)) for excess costs incurred in providing qualified prescription drug coverage—

"(A) for individuals enrolled with a prescription drug plan under this part;

"(B) for individuals enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; and

"(C) for individuals who are enrolled in a qualified retiree prescription drug plan.

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

"(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

"(1) A PDP sponsor offering a prescription drug plan under this part.

"(2) A Medicare+Choice organization that provides qualified prescription drug coverage under a Medicare+Choice plan under part C.

"(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (f)).

"(c) REINSURANCE PAYMENT AMOUNT.—

"(1) IN GENERAL.—Subject to subsection (d)(2) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying covered individual (as defined in subsection (g)(1)) for a coverage year (as defined in subsection (g)(2)) is equal to the sum of the following:

"(A) For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (3)) for the year that exceeds the initial copayment threshold specified in section 1860B(b)(2)(C), but does not exceed the initial coverage limit specified in section 1860B(b)(3), an amount equal to 30 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

"(B) For the portion of the individual's gross covered prescription drug costs for the year that exceeds the annual out-of-pocket threshold specified in 1860B(b)(4)(B), an amount equal to 80 percent of the allowable costs attributable to such gross covered prescription drug costs.

"(2) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid (net of average percentage rebates) under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

"(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to an enrollee

with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan (including costs attributable to administrative costs) for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

"(4) INDEXING DOLLAR AMOUNTS.—

"(A) AMOUNTS FOR 2005.—The dollar amounts applied under paragraph (1) for 2005 shall be the dollar amounts specified in such paragraph.

"(B) FOR 2006.—The dollar amounts applied under paragraph (1) for 2006 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2006.

"(C) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraph (1) for a year after 2006 shall be the amounts (under this paragraph) applied under paragraph (1) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

"(D) ROUNDING.—Any amount, determined under the preceding provisions of this paragraph for a year, which is not a multiple of $10 shall be rounded to the nearest multiple of $10.

"(d) ADJUSTMENT OF PAYMENTS.—

"(1) ESTIMATION OF PAYMENTS.—The Administrator shall estimate—

"(A) the total payments to be made (without regard to this subsection) during a year under this section; and

"(B) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

"(2) ADJUSTMENT.—The Administrator shall proportionally adjust the payments made under this section for a coverage year in such manner so that—

"(A) the total of the payments made for the year under this section is equal to 65 percent of the total payments described in paragraph (1)(B) during the year; and

"(B) the ratio of the total of the payments made for direct subsidies under subsection (a)(1) for the year to the total of the payments made for reinsurance subsidies for the year under subsection (a)(2) is equal to the ratio of 35 to 30.

"(3) RISK ADJUSTMENT.—To the extent the Administrator determines it appropriate to avoid risk selection, the payments made for direct subsidies under subsection (a)(1) are subject to adjustment based upon risk factors specified by the Administrator.

"(e) PAYMENT METHODS.—

"(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

"(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Medicare Prescription Drug Trust Fund.

"(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—

"(1) IN GENERAL.—For purposes of this section, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in paragraph (3)(A)) if, with respect to an individual enrolled (or

eligible to be enrolled) under this part who is covered under the plan, the following requirements are met:

"(A) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Administrator may require, that the coverage meets or exceeds the requirements for qualified prescription drug coverage.

"(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, and the accuracy of payments made.

"(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for issuance of certifications of the type described in section 1860A(c)(2)(D).

"(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to an individual who is enrolled under a qualified retiree prescription drug plan unless the individual is—

"(A) enrolled under this part;

"(B) is covered under the plan; and

"(C) is eligible to obtain qualified prescription drug coverage under section 1860A but did not elect such coverage under this part (either through a prescription drug plan or through a Medicare+Choice plan).

"(3) DEFINITIONS.—As used in this section:

"(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for individuals enrolled under this part (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

"(B) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

"(g) GENERAL DEFINITIONS.—For purposes of this section:

"(1) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

"(A) is enrolled with a prescription drug plan under this part;

"(B) is enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; or

"(C) is enrolled for benefits under this title and is covered under a qualified retiree prescription drug plan.

"(2) COVERAGE YEAR.—The term 'coverage year' means a calendar year in which covered outpatient drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

"SEC. 1860I. MEDICARE PRESCRIPTION DRUG TRUST FUND.

"(a) IN GENERAL.—There is created on the books of the Treasury of the United States a trust fund to be known as the 'Medicare Prescription Drug Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Except as otherwise provided in this section, the provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund under such section.

"(b) PAYMENTS FROM TRUST FUND.—

"(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Administrator certifies are necessary to make—

"(A) payments under section 1860G (relating to low-income subsidy payments);

"(B) payments under section 1860H (relating to subsidy payments); and

"(C) payments with respect to administrative expenses under this part in accordance with section 201(g).

"(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Trust Fund to the Grants to States for Medicaid account amounts the Administrator certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

"(c) DEPOSITS INTO TRUST FUND.—

"(1) LOW-INCOME TRANSFER.—There is hereby transferred to the Trust Fund, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

"(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b), reduced by the amount transferred to the Trust Fund under paragraph (1).

"(d) RELATION TO SOLVENCY REQUIREMENTS.—Any provision of law that relates to the solvency of the Trust Fund under this part shall take into account the Trust Fund and amounts receivable by, or payable from, the Trust Fund.

"SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C.

"(a) DEFINITIONS.—For purposes of this part:

"(1) COVERED OUTPATIENT DRUGS.—The term 'covered outpatient drugs' is defined in section 1860B(f).

"(2) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means such limit as established under section

1860B(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

"(3) MEDICARE PRESCRIPTION DRUG TRUST FUND.—The term 'Medicare Prescription Drug Trust Fund' means the Trust Fund created under section 1860I(a).

"(4) PDP SPONSOR.—The term 'PDP sponsor' means an entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

"(5) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' means health benefits coverage that—

"(A) is offered under a policy, contract, or plan by a PDP sponsor pursuant to, and in accordance with, a contract between the Administrator and the sponsor under section 1860D(b);

"(B) provides qualified prescription drug coverage; and

"(C) meets the applicable requirements of the section 1860C for a prescription drug plan.

"(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' is defined in section 1860B(a).

"(7) STANDARD COVERAGE.—The term 'standard coverage' is defined in section 1860B(b).

"(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

"(1) any reference to a Medicare+Choice plan included a reference to a prescription drug plan;

"(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

"(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D(b); and

"(4) any reference to part C included a reference to this part.".

(b) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of the enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) CONFORMING AMENDMENT PERMITTING WAIVER OF COST-SHARING.—Section 1128B(b)(3) (42 U.S.C. 1320a-7b(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting "; and"; and

(C) by adding at the end the following new subparagraph:

"(G) the waiver or reduction of any cost-sharing imposed under part D of title XVIII.".

(3) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this subtitle.

(c) STUDY ON TRANSITIONING PART B PRESCRIPTION DRUG COVERAGE.—Not later than January 1, 2004, the Medicare Benefits Administrator shall submit a report to Congress that makes recommendations regarding methods for providing benefits under part D of title XVIII of the Social Security Act for outpatient prescription drugs for which benefits are provided under part B of such title.

SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER THE MEDICARE+CHOICE PROGRAM.

(a) IN GENERAL.—Section 1851 (42 U.S.C. 1395w-21) is amended by adding at the end the following new subsection:

"(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

"(1) OFFER OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

"(A) IN GENERAL.—A Medicare+Choice organization may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare+Choice plan unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

"(B) CONSTRUCTION.—Nothing in this subsection shall be construed as—

"(i) requiring a Medicare+Choice plan to include coverage of qualified prescription drug coverage; or

"(ii) permitting a Medicare+Choice organization from providing such coverage to an individual who has not elected such coverage under section 1860A(b).

For purposes of this part, an individual who has not elected qualified prescription drug coverage under section 1860A(b) shall be treated as being ineligible to enroll in a Medicare+Choice plan under this part that offers such coverage.

"(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 1860C, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to a PDP sponsor and a prescription drug plan under part

D and shall submit to the Administrator the information described in section 1860F(a)(2). The Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

"(3) AVAILABILITY OF PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES AND DIRECT AND REINSURANCE SUBSIDY PAYMENTS FOR ORGANIZATIONS.—For provisions—

"(A) providing premium and cost-sharing subsidies to low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 1860G; and

"(B) providing a Medicare+Choice organization with direct and insurance subsidy payments for providing qualified prescription drug coverage under this part, see section 1860H.

"(4) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2005 shall be the 6-month period beginning with November 2004.

"(5) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 1860E.".

(b) CONFORMING AMENDMENTS.—Section 1851 (42 U.S.C. 1395w-21) is amended—

(1) in subsection (a)(1)—

(A) by inserting "(other than qualified prescription drug benefits)" after "benefits";

(B) by striking the period at the end of subparagraph (B) and inserting a comma; and

(C) by adding after and below subparagraph (B) the following:

"and may elect qualified prescription drug coverage in accordance with section 1860A."; and

(2) in subsection (g)(1), by inserting "and section 1860A(c)(2)(B)" after "in this subsection".

(c) EFFECTIVE DATE.—The amendments made by this section apply to coverage provided on or after January 1, 2005.

SEC. 103. MEDICAID AMENDMENTS.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

(1) REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) by striking "and" at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65) and inserting "; and"; and

(C) by inserting after paragraph (65) the following new paragraph:

"(66) provide for making eligibility determinations under section 1935(a).".

(2) NEW SECTION.—Title XIX is further amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

"SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

"SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall—

"(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 1860G;

"(2) inform the Administrator of the Medicare Benefits Administration of such determinations in cases in which such eligibility is established; and

"(3) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860G).

"(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

"(1) IN GENERAL.—The amounts expended by a State in carrying out subsection (a) are, subject to paragraph (2), expenditures reimbursable under the appropriate paragraph of section 1903(a); except that, notwithstanding any other provision of such section, the applicable Federal matching rates with respect to such expenditures under such section shall be increased as follows (but in no case shall the rate as so increased exceed 100 percent):

"(A) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 10 percent of the percentage otherwise payable (but for this subsection) by the State.

"(B)(i) For expenditures attributable to costs incurred during 2006 and each subsequent year through 2013, the otherwise applicable Federal matching rate shall be increased by the applicable percent (as defined in clause (ii)) of the percentage otherwise payable (but for this subsection) by the State.

"(ii) For purposes of clause (i), the 'applicable percent' for—

"(I) 2006 is 20 percent; or

"(II) a subsequent year is the applicable percent under this clause for the previous year increased by 10 percentage points.

"(C) For expenditures attributable to costs incurred after 2013, the otherwise applicable Federal matching rate shall be increased to 100 percent.

"(2) COORDINATION.—The State shall provide the Administrator with such information as may be necessary to properly allocate administrative expenditures described in

paragraph (1) that may otherwise be made for similar eligibility determinations.".

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by inserting before the semicolon the following: ", reduced by the amount computed under section 1935(c)(1) for the State and the quarter".

(2) AMOUNT DESCRIBED.—Section 1935, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

"(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

"(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2005) the amount computed under this subsection is equal to the product of the following:

"(A) MEDICARE SUBSIDIES.—The total amount of payments made in the quarter under section 1860G (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to individuals who are residents of the State and are entitled to benefits with respect to prescribed drugs under the State plan under this title (including such a plan operating under a waiver under section 1115).

"(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

"(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

"(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

"(A) 2005 is 90 percent;

"(B) a subsequent year before 2014, is the phase-out proportion for calendar quarters in the previous year decreased by 10 percentage points; or

"(C) a year after 2013 is 0 percent.".

(c) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935, as so inserted and amended, is further amended by adding at the end the following new subsection:

"(d) ADDITIONAL PROVISIONS.—

"(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a Medicare+Choice plan under part C of such title) and medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under the prescription drug plan or the Medicare+Choice plan selected by the individual.

"(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under section 1860A.".

(d) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1935, as so inserted and amended, is further amended—

(A) in subsection (a) in the matter preceding paragraph (1), by inserting "subject to subsection (e)" after "section 1903(a)";

(B) in subsection (c)(1), by inserting "subject to subsection (e)" after "1903(a)(1)"; and

(C) by adding at the end the following new subsection:

"(e) TREATMENT OF TERRITORIES.—

"(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

"(A) the previous provisions of this section shall not apply to residents of such State; and

"(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

"(2) PLAN.—The plan described in this paragraph is a plan that—

"(A) provides medical assistance with respect to the provision of covered outpatient drugs (as defined in section 1860B(f)) to low-income medicare beneficiaries; and

"(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

"(3) INCREASED AMOUNT.—

"(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

"(i) the aggregate amount specified in subparagraph (B); and

"(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

"(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

"(i) 2005, is equal to $20,000,000; or

"(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage in-

crease specified in section 1860B(b)(5) for the year involved.

"(4) REPORT.—The Administrator shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Administrator deems appropriate.".

(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting "and section 1935(e)(1)(B)" after "Subject to subsection (g)".

SEC. 104. MEDIGAP TRANSITION.

(a) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

"(v) COVERAGE OF PRESCRIPTION DRUGS.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, except as provided in paragraph (3) no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under this section on or after January 1, 2005, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs.

"(2) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN PRESCRIPTION DRUG COVERAGE UNDER PART D.—

"(A) IN GENERAL.—The issuer of a medicare supplemental policy—

"(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as 'A', 'B', 'C', 'D', 'E', 'F', or 'G' (under the standards established under subsection (p)(2)) and that is offered and is available for issuance to new enrollees by such issuer;

"(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

"(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy, in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

"(B) INDIVIDUAL COVERED.—An individual described in this subparagraph is an individual who—

"(i) enrolls in a prescription drug plan under part D; and

"(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as 'H', 'I', or 'J' under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

"(C) ENFORCEMENT.—The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of this paragraph in the same manner as they apply to the requirements of such subsection.

"(3) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Medicare Modernization and Prescription Drug Act of 2002, with respect to policies issued to individuals who are enrolled under part D, the changes in standards shall provide for at least two benefit packages (other than the core benefit package) that may provide for coverage of cost-sharing with respect to qualified prescription drug coverage under such part, except that such coverage may not cover the prescription drug deductible under such part. Two benefit packages shall be consistent with the following:

"(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

"(i) Coverage of 50 percent of the cost-sharing otherwise applicable, except coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

"(ii) No coverage of the part B deductible.

"(iii) Coverage for all hospital coinsurance for long stays (as in the current core benefit package).

"(iv) A limitation on annual out-of-pocket expenditures to $4,000 in 2005 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

"(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except as follows:

"(i) Substitute '75 percent' for '50 percent' in clause (i) of such subparagraph.

"(ii) Substitute '$2,000' for '$4,000' in clause (iv) of such subparagraph.

"(4) CONSTRUCTION.—Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met through the offering of other coverage under this subsection.".

SEC. 105. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM.

Title XVIII is amended by inserting after section 1806 the following new section:

"MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM

"SEC. 1807. (a) IN GENERAL.—The Secretary (or the Medicare Benefits Administrator pursuant to section 1808(c)(3)(C)) shall establish a program—

"(1) to endorse prescription drug discount card programs that meet the requirements of this section; and

"(2) to make available to medicare beneficiaries information regarding such endorsed programs.

"(b) REQUIREMENTS FOR ENDORSEMENT.—The Secretary may not endorse a prescription drug discount card program under this section unless the program meets the following requirements:

"(1) SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

"(2) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are available other than solely through mail order.

"(3) BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and counseling, and services to prevent adverse drug interactions.

"(4) INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

"(5) DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

"(6) QUALITY ASSURANCE.—The entity has in place adequate procedures for assuring quality service under the program.

"(7) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of

the negotiated retail price or the usual and customary price.

"(c) PROGRAM OPERATION.—The Secretary shall operate the program under this section consistent with the following:

"(1) PROMOTION OF INFORMED CHOICE.—In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall provide for the dissemination of information which compares the costs and benefits of such programs in a manner coordinated with the dissemination of educational information on Medicare+Choice plans under part C.

"(2) OVERSIGHT.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed programs with the requirements of this section, including verification of the discounts and services provided.

"(3) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1-800-medicare toll free telephone number for the receipt and response to inquiries and complaints concerning the program and programs endorsed under this section.

"(4) DISQUALIFICATION FOR ABUSIVE PRACTICES.—The Secretary shall revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in false or misleading marketing practices.

"(5) ENROLLMENT PRACTICES.—A medicare beneficiary may not be enrolled in more than one endorsed program at any time.

"(d) TRANSITION.—The Secretary shall provide for an appropriate transition and discontinuation of the program under this section at the time prescription drug benefits first become available under part D.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the program under this section."